		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 8000200

Facility Name: Graham Hospital

Address: 210 West Walnut Street (Number) Canton (City) 61520 (Zip Code)

County: Fulton

Telephone Number: 309-647-5240 **Fax #** 309-649-5111

IDPA ID Number: 37-0673506-004

Date of Initial License for Current Owners: 07/02/87

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Melissa Wilson **Telephone Number:** 309-647-5240 ext. 2256

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/04 to 06/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Melissa Wilson
(Title) Director of Accounting

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	32	Skilled (SNF)	32	11,680	1
2		Skilled Pediatric (SNF/PED)			2
3	22	Intermediate (ICF)	22	8,030	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	54	TOTALS	54	19,710	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	363	1,723	6,468	8,554	8
9	SNF/PED					9
10	ICF	2,406	5,114	23	7,543	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,769	6,837	6,491	16,097	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.67%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 6,468

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/05 Fiscal Year: 6/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Graham Hospital # 8000200 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	223,735	188,829		412,564		412,564		412,564			1
2	Food Purchase		214,608		214,608		214,608		214,608			2
3	Housekeeping	2,084	1,758		3,842		3,842		3,842			3
4	Laundry	9,641	134,027		143,668		143,668		143,668			4
5	Heat and Other Utilities											5
6	Maintenance	122,901	289,918		412,819		412,819		412,819			6
7	Other (specify):*											7
8	**TOTAL General Services**	358,361	829,140		1,187,501		1,187,501		1,187,501			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,485,401	105,774		1,591,175		1,591,175		1,591,175			10
10a	Therapy											10a
11	Activities											11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	74,700	19,488		94,188		94,188		94,188			15
16	**TOTAL Health Care and Programs**	1,560,101	125,262		1,685,363		1,685,363		1,685,363			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	213,450	303,120		516,570	(29,565)	487,005		487,005			21
22	Employee Benefits & Payroll Taxes			424,098	424,098		424,098		424,098			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			344,738	344,738		344,738		344,738			25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	**TOTAL General Administration**	213,450	303,120	768,836	1,285,406	(29,565)	1,255,841		1,255,841			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,131,912	1,257,522	768,836	4,158,270	(29,565)	4,128,705		4,128,705			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Graham Hospital #8000200 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			133,222	133,222		133,222	277,589	410,811			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			133,222	133,222		133,222	277,589	410,811			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					29,565	29,565		29,565			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					29,565	29,565		29,565			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,131,912	1,257,522	902,058	4,291,492		4,291,492	277,589	4,569,081			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	277,589	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 277,589		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 277,589		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Graham Hospital

ID# 8000200

Report Period Beginning: 07/01/04

Ending: 06/30/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Graham Hospital **#** 8000200 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Graham Hospital** **#** **8000200** **Report Period Beginning:** **07/01/04** **Ending:** **06/30/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	**277,589**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**277,589**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**32**
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
37	**TOTAL Ownership**	**277,589**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**277,589**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**38**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41**
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**
43	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
44	**TOTAL Special Cost Centers**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**277,589**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**277,589**	**45**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Graham Hospital Association	100%	None				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Graham Hospital **#** 8000200 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Graham Hospital COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 8000200

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,688 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	ECF/SNF	16,668	VARIOUS	$	1
2					2
3	TOTALS	16,668		$	3

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1971		$ 1,047,221	$		$	$	$ 1,047,221	4
5			1972		866					866	5
6			1975		30,771					30,771	6
7			1976		1,880					1,880	7
8			1977		1,331,168	29,232	VARIOUS	29,232		1,006,004	8
	Improvement Type**										
9	Various Building Improvements			1978	187,881		Various			187,881	9
10	Various Building Improvements			1980	2,093		Various			2,093	10
11	Various Building Improvements			1982	5,227		Various			5,227	11
12	Various Building Improvements			1984	1,169,963	16,877	Various	16,877		879,061	12
13	Various Building Improvements			1985	34,258	857	Various	857		34,258	13
14	Various Building Improvements			1987	89,317	1,683	Various	1,683		85,502	14
15	Various Building Improvements			1988	52,287	70	Various	70		51,937	15
16	Various Building Improvements			1990	28,254	185	Various	185		28,168	16
17	Various Building Improvements			1991	125,804	6,364	Various	6,364		109,467	17
18	Various Building Improvements			1992	16,693	437	Various	437		15,995	18
19	Various Building Improvements			1993	19,686	837	Various	837		13,361	19
20	Various Building Improvements			1994	76,132	1,545	Various	1,545		65,932	20
21	Various Building Improvements			1995	32,594	879	Various	879		30,430	21
22	Various Building Improvements			1996	47,691	4,121	Various	4,121		44,431	22
23	Various Building Improvements			1997	24,479	1,778	Various	1,778		20,741	23
24	Various Building Improvements			1998	26,173	1,525	Various	1,525		18,086	24
25	Various Building Improvements			1999	11,097	608	Various	608		3,953	25
26	Various Building Improvements			2000	800,069	53,938	Various	53,938		296,660	26
27	Various Building Improvements			2001	112,532	9,149	Various	9,149		40,678	27
28	PROJ. 01.08 MAPLE STREET PATIO--LANDSCAPING			2002	11,778	2,356	5	2,356		8,245	28
29	PROJ. 01.08 MAPLE ST. PATIO--SMOKING SHELTER/INSTA			2002	7,129	475	15	475		1,663	29
30	PROJ. 01.08 MAPLE ST PATIO--PROF SERVICES JIM RICK			2002	1,494	100	15	100		349	30
31	PROJ 01.08 MAPLE ST. PATIO			2002	409	41	10	41		143	31
32	PROJ. 01.08 MAPLE ST PATIO--HANDSRAIL, STEPS, FOUN			2002	2,565	171	15	171		599	32
33	PROJ. 01.11 RADIOLOGY RM 5 RENO--ARCHITECT FEES			2002	2,836	189	15	189		662	33
34	PROJ 01.11 RADIOLOGY RM 5 RENO-PROF SERVICES RICKA			2002	828	55	15	55		193	34
35	PROJ 01.12 SON RENO--CEILING TILE			2002	1,077	135	8	135		471	35
36	PROJ 01.12 SON RENO--RENOVATION			2002	2,595	260	10	260		908	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PROJ. 01.12 SON RENO--PROFESSIONAL FEES J. RICKARD	2002	$ 5,795	$ 386	15	$ 386	$	$ 1,352	37
38	PROJ. 01.12 SON RENO--FLOOR TILE	2002	1,150	58	20	58		201	38
39	PROJ 02.02 ADMIN OFFICE RENO--CARPET AND PAINT	2002	4,899	980	5	980		3,429	39
40	PROJ. 02.02 ADMIN OFFICE RENO--CEILING TILE	2002	773	97	8	97		338	40
41	PROJ. 02.02 ADMIN OFFICE RENO--RENOVATION	2002	1,211	121	10	121		424	41
42	PROJ. 02.02 ADMIN OFFICE RENO--ARCHITECT FEES	2002	606	40	15	40		141	42
43	PROJ. 02.02 ADMIN OFFICE RENO--PROF FEES J. RICKAR	2002	2,353	157	15	157		549	43
44	PROJ. 02.05 LAB RENO--COUNTER TOPS	2002	523	35	15	35		122	44
45	PROJ 02.04 FIRE CAULKING-- FIRE CAULKING & FIRE ST	2002	2,130	426	5	426		1,491	45
46	PROJ 02.04 FIRE CAULKING--TILE	2002	564	71	8	71		247	46
47	PROJ 02.04 FIRE CAULKING	2002	5,194	346	15	346		1,212	47
48	PROJ 02.04 FIRE CAULKING BRASS ANGLE HOSE VALVES,	2002	673	27	25	27		94	48
49	PROJ 02.07 RELOCATE HOME HEALTH--RENOVATION OF HOU	2002	770	154	5	154		539	49
50	PROJ 02.07 RELOCATE HOME HEALTH--INSTALLATION OF C	2002	1,007	201	5	201		705	50
51	PROJ 02.07 RELOCATE HOME HEATLH--RENOVATION OF HOU	2002	431	29	15	29		101	51
52	PROJ 02.07 RELOCATE HOME HEALTH--REPLACE DRAIN IN	2002	648	32	20	32		113	52
53	PROJ 02.08 RENOVATE ORTHOPEDIC OFFICE AREA	2002	498	33	15	33		116	53
54	TUCKPOINT AND SEAL '68 BUILDING	2002	29,498	1,475	20	1,475		5,162	54
55	AUTOMATIC DOORS FOR EMERGENCY DEPT	2002	2,354	235	10	235		824	55
56	01.07 MRI PROJ--PAINT, ETC.	2002	171	34	5	34		119	56
57	01.07 MRI PROJ--PROF SERV BISHOP BROS	2002	215,787	14,386	15	14,386		50,350	57
58	01.07 MRI PROJ--PROF SERV PHILLIPS SWAGER	2002	23,367	1,558	15	1,558		5,452	58
59	01.07 MRI PROJ--PROF SERV RICKARD'S	2002	1,751	117	15	117		409	59
60	01.07 MRI PROJ--CEMENT CYLINDERS, DOOR CLOSURE	2002	820	55	15	55		191	60
61	01.04 LOBBY/ATRIUM RENOVATION--PAINT, ETC.	2002	335	67	5	67		234	61
62	01.04 LOBBY/ATRIUM RENOVATION--CEILING TILE AND CR	2002	1,967	246	8	246		861	62
63	01.04 LOBBY/ATRIUM RENOVATION--SIGNS, THERMOSTATES	2002	1,467	147	10	147		489	63
64	01.04 LOBBY/ATRIUM RENOVATION--PROF SERV BISHOP BR	2002	197,835	13,189	15	13,189		46,161	64
65	01.04 LOBBY/ATRIUM RENOVATION--PROF SERV PHILLIPS	2002	21,155	1,410	15	1,410		4,936	65
66	01.04 LOBBY/ATRIUM RENOVATION--PROF SERV RICKARD	2002	3,742	249	15	249		873	66
67	01.04 LOBBY/ATRIUM RENOVATION--RENOVATION	2002	203	14	15	14		47	67
68	01.04 LOBBY/ATRIUM RENOVATION--WASTE RECEPTACLES,	2002	946	63	15	63		221	68
69	01.04 LOBBY/ATRIUM RENOVATION--MAIL ROOM RENOVATIO	2002	1,624	108	15	108		379	69
70	**TOTAL (lines 4 thru 69)**		$ 5,837,094	$ 170,413		$ 170,413	$	$ 4,161,718	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,837,094	$ 170,413		$ 170,413	$	$ 4,161,718	1
2	01.04 LOBBY/ATRIUM RENOVATION--REPAIR FLASHINGS ON	2002	2,627	175	15	175		613	2
3	01.04 LOBBY/ATRIUM RENOVATION--REMOVE TILE GROUND	2002	1,165	58	20	58		204	3
4	01.04 LOBBY/ATRIUM RENOVATION--CABLE	2002	1,267	63	20	63		222	4
5	01.04 LOBBY/ATRIUM RENOVATION--PROF SERV BISHOP BR	2002	11,630	582	20	582		2,035	5
6	01.04 LOBBY/ATRIUM RENOVATION--RENOVATION	2002	317	16	20	16		55	6
7	PROJ 01.04 LOBBY/ATRIUM RENOVATION--AXIA-JONESMAYE	2002	1,032	69	15	69		241	7
8	LOADING DOCK DOORS	2003	1,151	115	10	115		288	8
9	RE ROOF '59 BUILDING	2003	6,162	616	10	616		1,541	9
10	FIRE RATED DOORD (2)	2003	1,471	74	20	74		184	10
11	PROJ 01.04 LOBBY/ATRIUM RENOVATION PROF SERV BISHO	2003	15,753	1,050	15	1,050		2,625	11
12	PROJ 01.04 LOBBY/ATRIUM RENOVATION PROF SERV PHILL	2003	6,777	452	15	452		1,130	12
13	PROJ 01.06 ACUTE CARE RENOVATION PAINT, WATER DISP	2003	1,266	253	5	253		633	13
14	PROJ 01.06 ACUTE CARE RENOVATION PROF SERV RICKARD	2003	10,789	1,349	8	1,349		3,372	14
15	PROJ 01.06 ACUTE CARE RENOVATION FLOOR TILES	2003	3,889	389	10	389		972	15
16	PROJ 01.06 ACUTE CARE RENOVATION SIGNAGE	2003	1,015	102	10	102		254	16
17	PROJ 01.06 ACUTE CARE RENOVATION THERMOSTATS,LIGHT	2003	3,320	332	10	332		830	17
18	PROJ 01.06 ACUTE CARE RENOVATION BUILDING MATERIAL	2003	13,366	891	15	891		2,228	18
19	PROJ 01.06 ACUTE CARE RENOVATION PROF SERV RICKARD	2003	46,648	3,110	15	3,110		7,775	19
20	PROJ 01.06 ACUTE CARE RENOVATION PROF SERV SIMPSON	2003	1,002	67	15	67		167	20
21	PROJ 01.06 ACUTE CARE RENOVATION PROF SERV BALAGNA	2003	3,236	216	15	216		539	21
22	PROJ 01.06 ACUTE CARE RENOVATION PROF SERV G-M MEC	2003	203	14	15	14		34	22
23	PROJ 01.06 ACUTE CARE RENOVATION OAK DOORS	2003	1,711	114	15	114		285	23
24	PROJ 01.06 ACUTE CARE RENOVATION PROF SERV J A SEX	2003	3,141	157	20	157		393	24
25	PROJ 01.06 ACUTE CARE RENOVATION PROF SERV RKE	2003	13,283	664	20	664		1,660	25
26	PROJ 01.07 MRI PROJECT ADDL SUPPLIES	2003	489	33	15	33		82	26
27	PROJ 02.04 FIRE CAULKING	2003	582	39	15	39		97	27
28	PROJ 02.05 LAB RENOVATION PROF SERV RICKARD'S	2003	303	30	10	30		76	28
29	PROJ 02.14 HOT WATER HEATER ASBESTOS ABATEMENT	2003	2,112	211	10	211		528	29
30	PROJ 02.14 HOT WATER HEATER PROF SERV RICKARD'S	2003	750	50	15	50		125	30
31	PROJ 02.15 LOBBY ENTRANCE PROF SERV KEMPER CONSTRU	2003	53,914	3,594	15	3,594		8,986	31
32	PROJ 02.15 LOBBY ENTRANCE PROF SERV PHILLIPS SWAGE	2003	362	24	15	24		60	32
33	PROJ 02.15 LOBBY ENTRANCE SIGNAGE	2003	201	20	10	20		50	33
34	TOTAL (lines 1 thru 33)		$ 6,048,028	$ 185,342		$ 185,342	$	$ 4,200,002	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,048,028	$ 185,342		$ 185,342	$	$ 4,200,002	1
2	PROJ 02.16 RADIOLOGY RENOVATION CARPET	2003	1,607	321	5	321		803	2
3	PROJ 02.16 RADIOLOGY RENOVATION PROF SERV RICKARD'	2003	3,018	201	15	201		503	3
4	PROJ 02.16 RADIOLOGY RENOVATION PAINTING, MATERIAL	2003	521	35	15	35		87	4
5	PROJ 02.18 DISH ROOM CEILING, WALL WORK	2003	1,662	208	8	208		519	5
6	PROJ 01.06 ACUTE CARE RENOVATION PROF SERV AXIA JO	2003	115,966	7,731	15	7,731		19,328	6
7	PROJ 01.06 ACUTE CARE RENO IDPH REVIEW FEE	2003	4,181	278	15	278		697	7
8	PROJ 01.06 ACUTE CARE RENO PROF SERV PHILLIPS SWAG	2003	10,143	676	15	676		1,690	8
9	PROJ 01.06 ACUTE CARE RENO PROF SERV RICKARD'S	2003	672	45	15	45		112	9
10	PROJ 01.06 ACUTE CARE RENO LINTELS FOR HR MOVE BLU	2003	2,069	138	15	138		345	10
11	PROJ 01.06 ACUTE CARE RENO CARPET	2003	5,390	1,078	5	1,078		2,695	11
12	PROJ 01.06 ACUTE CARE RENO ASBESTOS ABATEMENT	2003	3,776	252	15	252		629	12
13	PROJ 01.06 ACUTE CARE RENO CEILING TILE	2003	6,388	799	8	799		1,996	13
14	PROJ 01.06 ACUTE CARE RENO RUBBISH REMOVAL	2003	3,855	257	15	257		642	14
15	PROJ 01.06 ACUTE CARE RENO DRYWALL	2003	4,233	282	15	282		705	15
16	BOILER ROOM ROOFS	2004	8,758	876	10	876		1,314	16
17	XRAY ATRIUM ROOF REPAIR	2004	1,271	127	10	127		191	17
18	PROJ 02.14 HOT WATER SYSTEM ASBESTOS ABATEMENT	2004	836	56	15	56		84	18
19	PROJ 02.17 FLOOR CEILING TILE REPLACEMENT-FLOOR PA	2004	886	177	5	177		266	19
20	PROJ 02.17 FLOOR CEILING TILE REPLACEMENT-CEILING	2004	4,989	624	8	624		936	20
21	PROJ 02.17 FLOOR CEILING TILE REPLACEMENT-CEILING	2004	16,108	2,013	8	2,013		3,020	21
22	PROJ 02.17 FLOOR CEILING TILE REPLACEMENT-CEILING	2004	978	122	8	122		183	22
23	PROJ 02.17 FLOOR CEILING TILE REPLACEMENT-LIGHT IN	2004	617	62	10	62		92	23
24	PROJ 02.17 FLOOR CEILING TILE REPLACEMENT-LIGHTS	2004	3,739	374	10	374		561	24
25	PROJ 02.17 FLOOR CEILING TILE REPLACEMENT-T-8 LAY	2004	618	41	15	41		62	25
26	PROJ 02.17 FLOOR CEILING TILE REPLACEMENT-MATERIAL	2004	704	47	15	47		70	26
27	PROJ 02.17 FLOOR CEILING TILE REPLACEMENT-POUR CON	2004	796	53	15	53		80	27
28	PROJ 02.17 FLOOR CEILING TILE REPLACEMENT-CEILING	2004	910	46	20	46		68	28
29	PROJ 02.17 FLOOR CEILING TILE REPLACEMENT-ELECTRIC	2004	974	49	20	49		73	29
30	PROJ 02.17 FLOOR CEILING TILE REPLACEMENT-REPLACE	2004	111	4	25	4		7	30
31	PROJ 03.02 2E RENO-LOCKS, PAINTING WALLCOVERING	2004	1,279	256	5	256		384	31
32	PROJ 03.02 2E RENO-CARPET	2004	862	172	5	172		259	32
33	PROJ 03.02 2E RENO-CEILING TILE CROSS T'S	2004	2,018	252	8	252		378	33
34	TOTAL (lines 1 thru 33)		$ 6,257,963	$ 202,994		$ 202,994	$	$ 4,238,781	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,257,963	$ 202,994		$ 202,994	$	$ 4,238,781	1
2	PROJ 03.02 2E RENO-WINDOWS, COVE BASE, FLOOR TILE	2004	1,508	151	10	151		226	2
3	PROJ 03.02 2E RENO-REUPHOLSTER FURNITURE	2004	1,203	100	12	100		150	3
4	PROJ 03.02 2E RENO-DRYWALL	2004	4,131	275	15	275		413	4
5	PROJ 03.02 2E RENO-COUNTER CABINET NURSE'S STATION	2004	2,746	183	15	183		275	5
6	PROJ 03.02 2E RENO-CABLE	2004	422	21	20	21		32	6
7	PROJ 03.02 2E RENO-PLUMBING	2004	538	27	20	27		40	7
8	PROJ 03.03 LIFE SAFETY-FIRE CAULKING	2004	1,099	220	5	220		330	8
9	PROJ 03.03 LIFE SAFETY-PAINTING, MATERIALS	2004	3,770	754	5	754		1,131	9
10	PROJ 03.03 LIFE SAFETY-CEILING REPLACEMENT	2004	21,677	2,710	8	2,710		4,064	10
11	PROJ 03.03 LIFE SAFETY-LIGHT TENTING	2004	1,783	223	8	223		334	11
12	PROJ 03.03 LIFE SAFETY-LIGHTING, FIRE DAMPERS	2004	12,021	1,202	10	1,202		1,803	12
13	PROJ 03.03 LIFE SAFETY-CONTRUCTION LABOR, MATERIAL	2004	70,053	4,670	15	4,670		7,005	13
14	PROJ 03.03 LIFE SAFETY-FIRE RATED DOORS, GATES	2004	4,028	201	20	201		302	14
15	PROJ 03.03 LIFE SAFETY-DIFFUSERS/DAMPERS	2004	7,458	298	25	298		448	15
16	PROJ 03.05 PACS SYSTEM-WIRING SUPPLIES, GIG SWITCH	2004	2,367	118	20	118		178	16
17	PROJ 03.06 SLEEP STUDY ROOM CONSTRUCTION-PAINT, CA	2004	1,205	241	5	241		362	17
18	PROJ 03.06 SLEEP STUDY RM CONSTRUCT-LOCKS	2004	478	48	10	48		72	18
19	PROJ 03.08 LAB RENO	2004	210,886	14,059	15	14,059		21,089	19
20	PROJ 03.08 LAB RENO-FLAD ARCHITECT SERVICES	2004	24,183	1,612	15	1,612		2,418	20
21	PROJ 03.08 LAB RENO-CONSULTATION MARTHA ROBBINS	2004	750	50	15	50		75	21
22	PROJ 03.08 LAB RENO-PLUMBING, DUCTWORK	2004	2,628	131	20	131		197	22
23	PROJ 03.08 LAB RENO-INSULATION REPLACE AROUND DUCT	2004	1,102	44	25	44		66	23
24	PROJ 03.08 LAB RENO-REBUILD MOVE VENT LINES	2004	490	33	15	33		49	24
25	PROJ 03.09 PATIENT REGIS RENO-CARPET, PAINT	2004	948	190	5	190		284	25
26	PROJ 03.09 PATIENT REGIS RENO-CEILING TILE	2004	2,707	338	8	338		508	26
27	PROJ 03.09 PATIENT REGIS RENO-SIGNAGE, LIGHTING, F	2004	1,565	157	10	157		235	27
28	PROJ 03.09 PATIENT REGIS RENO-DRYWALL, DOORS, FRAM	2004	5,716	381	15	381		572	28
29	PROJ 03.10 SON RENO-PAINT, CARPET	2004	2,088	418	5	418		626	29
30	PROJ 03.10 SON RENO - CEILING INSTALL	2004	5,057	632	8	632		948	30
31	PROJ 04.01 WINDOW '59 BLDG-REPLACE AND INSTALL	2004	14,385	959	15	959		1,439	31
32	PROJ 04.03 HR OFFICE RENO-PAINT, CARPET, DRYWALL,	2004	1,299	87	15	87		130	32
33	PROJ 04.06 MEDICAL RECORDS-PAINT, CARPET, BLINDS	2004	4,206	841	5	841		1,262	33
34	TOTAL (lines 1 thru 33)		$ 6,672,460	$ 234,368		$ 234,368	$	$ 4,285,844	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,672,460	$ 234,368		$ 234,368	$	$ 4,285,844	1
2	PROJ 04.06 MEDICAL RECORDS-CEILING REPLACEMENT	2004	3,824	478	8	478		717	2
3	PROJ 04.06 MEDICAL RECORDS-LIGHT FIXTURES, COVE BA	2004	989	99	10	99		148	3
4	PROJ 04.06 MEDICAL RECORDS-PVC VENT, DUCTS, RETURN	2004	790	40	20	40		59	4
5	04.09 PHASE II UTILITY YARD- IDPH FEE	2005	2,090	70	15	70		70	5
6	04.09 PHASE II UTILITY YARD- FREIGHT CRANE RIGGING	2005	7,331	244	15	244		244	6
7	04.09 PHASE II UTILITY YARD- NFPA TESTING	2005	1,394	46	15	46		46	7
8	04.09 PHASE II UTILITY YARD- FLAD & ASSOC SERVICES	2005	28,278	943	15	943		943	8
9	04.09 PHASE II UTILITY YARD- INSULATE OUTDOOR AIR	2005	602	15	20	15		15	9
10	04.09 PHASE II UTILITY YARD- PJ HOERR SERVICES	2005	807,446	26,915	15	26,915		26,915	10
11	04.10 PHARMACY RENOVATION	2005	3,339	111	15	111		111	11
12	04.12 LIFE SAFETY RENOVATION- CONCRETE, DRYWALL, S	2005	2,905	291	5	291		290	12
13	04.12 LIFE SAFETY RENOVATION- SIGNS, FIXTURES, ACC	2005	1,256	63	10	63		63	13
14	04.12 LIFE SAFETY RENOVATION- PJ HOERR SERVICES	2005	50,200	1,673	15	1,673		1,673	14
15	04.12 LIFE SAFETY RENOVATION- KIRWAN ASBESTOS REMO	2005	1,463	49	15	49		49	15
16	04.12 LIFE SAFETY RENOVATION- OUTSIDE STEPS	2005	6,872	229	15	229		229	16
17	04.12 LIFE SAFETY RENOVATION- RICKARD'S CONSTRUCTI	2005	16,505	550	15	550		550	17
18	04.12 LIFE SAFETY RENOVATION- FLAD & ASSOC SERVICE	2005	8,506	284	15	284		284	18
19	04.12 LIFE SAFETY RENOVATION- OAK DOOR	2005	1,376	46	15	46		46	19
20	04.12 LIFE SAFETY RENOVATION- DRYWALL, PAINTING &	2005	6,882	229	15	229		229	20
21	04.15 SON CEILINGS- CARPET & PAINT	2005	1,657	166	5	166		166	21
22	04.15 SON CEILINGS- TILE, LAMPS, BALLASTS & COVE B	2005	1,755	88	10	88		88	22
23	04.15 SON CEILINGS- CEILING TILE & LABOR TO INSTAL	2005	2,492	83	15	83		83	23
24	05.02 OB RENOVATION	2005	739	74	5	74		74	24
25	Building Service Equipment	1971	631,573		VARIOUS			631,573	25
26	Building Service Equipment	1977	1,416,541		VARIOUS			1,416,541	26
27	Building Service Equipment	1983	114,728		VARIOUS			114,728	27
28	Building Service Equipment	1984	1,502,306	1,345	VARIOUS	1,345		1,497,594	28
29	Building Service Equipment	1986	2,699	135	VARIOUS	135		2,624	29
30	Building Service Equipment	1987	286,486	8,792	VARIOUS	8,792		262,223	30
31	Building Service Equipment	1988	13,067	458	VARIOUS	458		11,530	31
32	Building Service Equipment	1989	11,786		VARIOUS			11,786	32
33	Building Service Equipment	1990	13,887	365	VARIOUS	365		13,852	33
34	TOTAL (lines 1 thru 33)		$ 11,624,224	$ 278,249		$ 278,249	$	$ 8,281,387	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 11,624,224	$ 278,249		$ 278,249	$	$ 8,281,387	1
2	Building Service Equipment	1991	6,731	211	VARIOUS	211		5,321	2
3	Building Service Equipment	1992	23,032	384	VARIOUS	384		21,827	3
4	Building Service Equipment	1993	21,263	710	VARIOUS	710		17,108	4
5	Building Service Equipment	1994	91,510	3,580	VARIOUS	3,580		67,681	5
6	Building Service Equipment	1995	8,871	492	VARIOUS	492		6,554	6
7	Building Service Equipment	1996	29,760	2,656	VARIOUS	2,656		25,738	7
8	Building Service Equipment	1997	91,231	8,928	VARIOUS	8,928		76,256	8
9	Building Service Equipment	1998	50,894	3,618	VARIOUS	3,618		27,136	9
10	Building Service Equipment	1999	43,420	3,584	VARIOUS	3,584		27,484	10
11	Building Service Equipment	2000	17,185	1,470	VARIOUS	1,470		8,085	11
12	Building Service Equipment	2001	360,658	23,486	VARIOUS	23,486		105,685	12
13	PROJ 01.11 RADIOLOGY RM 5 RENO--ELECTRICAL WIRING	2002	1,607	80	20	80		281	13
14	PROJ. 01.12 SON RENOVATION--ELECTRICAL	2002	645	32	20	32		113	14
15	PROJ 02.07 RELOCATE HOME HEALTH 24 PORT 4400 SWITC	2002	1,807	361	5	361		1,265	15
16	PROJ 02.07 RELOCATE HOME HEALTH RUN ELECTRICITY FO	2002	6,867	1,373	5	1,373		4,807	16
17	PROJ 02.07 RELOCATE HOME HEALTH EXIT LIGHTS, LIGHT	2002	1,437	144	10	144		503	17
18	PROJ 02.07 RELOCATE HOME HEALTH ELECTRICAL CONNECT	2002	2,247	112	20	112		393	18
19	INFRARED DETECTORS FOR #2 ELEVATORS	2003	1,446	72	15	72		181	19
20	COMPRESSOR FOR 400 TON CHILLER	2003	3,194	213	20	213		532	20
21	HOIST ROPES FOR ELEVATOR 2	2003	1,439	72	20	72		180	21
22	NEW PIT CHANNELS AND BUFFERS FOR ELEVATOR 2	2003	1,273	64	10	64		159	22
23	PHONE SYSTEM SOFTWARE	2003	1,968	197	20	197		492	23
24	ELEVATOR 3 UPGRADE	2003	1,243	62	20	62		155	24
25	PAGING SYSTEM	2003	1,248	62	20	62		156	25
26	UPGRADE ELEVATORS 5 & 6	2003	64,842	3,242	20	3,242		8,105	26
27	ELEVATOR 3 UPGRADE	2003	2,763	138	20	138		345	27
28	ELEVATOR 2 UPGRADE	2003	460	23	20	23		58	28
29	PROJ 01.06 ACUTE CARE RENOVATION (26) VAV UCM'S SU	2003	505	25	20	25		63	29
30	PROJ 01.06 ACUTE CARE RENOVATION PIPE/INSULATION D	2003	11,951	598	20	598		1,494	30
31	PROJ 01.06 ACUTE CARE RENOVATION ELECTRICAL/DUCT W	2003	13,501	675	20	675		1,688	31
32	PROJ 01.06 ACUTE CARE RENOVATION AUTOMATIC SPRINKL	2003	2,547	102	25	102		255	32
33	PROJ 02.01 225 TON A/C REPLACEMENT WATER METER	2003	627	63	10	63		157	33
34	TOTAL (lines 1 thru 33)		$ 12,492,396	$ 335,078		$ 335,078	$	$ 8,691,644	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 12,492,396	$ 335,078		$ 335,078	$	$ 8,691,644	1
2	PROJ 02.01 225 TON A/C REPLACEMENT 120V STARTER, K	2003	786	79	10	79		197	2
3	PROJ 02.01 225 TON A/C REPLACEMENT PROF SERV PHILL	2003	30,987	2,066	15	2,066		5,164	3
4	PROJ 02.01 225 TON A/C REPLACEMENT HVAC SYSTEM (CH	2003	161,717	10,781	15	10,781		26,953	4
5	PROJ 02.01 225 TON A/C REPLACEMENT REPAIR PUMP	2003	874	87	10	87		218	5
6	PROJ 02.14 HOT WATER HEATER	2003	7,187	719	10	719		1,797	6
7	PROJ 02.16 RADIOLOGY RENOVATION AUTOMATIC SPRINKLE	2003	545	22	25	22		55	7
8	PROJ 01.06 ACUTE CARE RENO AIR BALANCING	2003	784	52	15	52		131	8
9	PROJ 01.06 ACUTE CARE RENO PHILLIPS HVAC STUDY	2003	1,925	128	15	128		321	9
10	PROJ 01.06 ACUTE CARE RENO HVAC/PLUMBINB	2003	28,485	1,424	20	1,424		3,561	10
11	PROJ 01.06 ACUTE CARE RENO HOT WATER MAINS/DUCT WO	2003	36,409	1,456	25	1,456		3,641	11
12	PROJ 02.01 225 TON A/C REPLACE--SUPPLIES	2003	1,197	60	20	60		150	12
13	PROJ 02.01 225 TON A/C REPLACE REMOVE/INSTALL TANK	2003	3,637	146	25	146		364	13
14	PROJ 02.01 225 TON A/C REPLACE STARTER W/FACT MODI	2003	1,620	65	25	65		184	14
15	PROJ 02.12 FIRE/SECURITY SYS-INSTALLATION	2004	51,550	5,155	10	5,155		7,733	15
16	PROJ 02.12 FIRE/SECURITY SYS-OBERLANDER	2004	69,848	6,985	10	6,985		10,477	16
17	PROJ 02.12 FIRE/SECURITY SYS-ARCHITECT	2004	3,152	315	10	315		473	17
18	PROJ 02.12 FIRE/SECURITY SYS-MATERIALS	2004	433	43	10	43		65	18
19	PROJ 02.12 FIRE/SECURITY SYS-ASBESTOS ABATEMENT	2004	934	62	15	62		93	19
20	PROJ 02.12 FIRE/SECURITY SYS-CITY OF CANTON	2004	647	65	10	65		97	20
21	PROJ 02.12 FIRE/SECURITY SYS-FITTER LABOR	2004	1,141	76	15	76		114	21
22	PROJ 03.08 LAB RENO-LIGHT FIXTURES, BALLASTS, SUPP	2004	1,003	100	10	100		150	22
23	INSTALL 20 TON COMPRESSOR	2004	2,602	173	15	173		260	23
24	ELEVATOR UPGRADE	2004	20,695	1,035	20	1,035		1,552	24
25	A/C FOR PHONE ROOM	2004	3,702	247	15	247		370	25
26	HOT WATER PUMP	2004	807	54	15	54		81	26
27	A/C FOR 1ST FLOOR CONFERENCE ROOM	2005	504	25	10	25		25	27
28	EMERGENCY RADIO BACKUP SYSTEM	2005	954	32	15	32		32	28
29	MARLO CHILLED WATER COOLER	2005	810	41	10	41		41	29
30	GARBAGE DISPOSAL SN271140079	2005	1,475	148	5	148		147	30
31	04.16 PYXIS	2005	1,107	55	10	55		55	31
32	05.11 WIRELESS NETWORK	2005	32,059	1,603	10	1,603		1,603	32
33	Fixed Equipment	1972	5,755					5,755	33
34	TOTAL (lines 1 thru 33)		$ 12,967,727	$ 368,377		$ 368,377	$	$ 8,763,503	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 12,967,727	$ 368,377		$ 368,377	$	$ 8,763,503	1
2	Fixed Equipment	1973	4,926		VARIOUS			4,926	2
3	Fixed Equipment	1975	989		VARIOUS			989	3
4	Fixed Equipment	1980	599		VARIOUS			599	4
5	Fixed Equipment	1981	1,188		VARIOUS			1,188	5
6	Fixed Equipment	1987	37,780	1,786	VARIOUS	1,786		35,007	6
7	Fixed Equipment	1988	1,439	72	VARIOUS	72		1,255	7
8	Fixed Equipment	1992	3,936	159	VARIOUS	159		3,688	8
9	Fixed Equipment	1994	4,732		VARIOUS			4,720	9
10	Fixed Equipment	1995	7,700	384	VARIOUS	384		4,032	10
11	Fixed Equipment	1996	1,422		VARIOUS			1,418	11
12	Fixed Equipment	1998	2,006	113	VARIOUS	113		1,257	12
13	Fixed Equipment	1999	2,891	227	VARIOUS	227		2,097	13
14	Fixed Equipment	2001	20,918	1,550	VARIOUS	1,550		6,976	14
15	PROJ. 01.12 SON RENOVATION--LOCKS	2002	920	184	5	184		644	15
16	PROJ 01.06 ACUTE CARE RENOVATION CARPET SURGERY WA	2003	3,651	730	5	730		1,825	16
17	PROJ 01.06 ACUTE CARE RENOVATION BED STATION INTER	2003	1,025	103	10	103		256	17
18	PROJ 01.06 ACUTE CARE RENOVATION FIRE DETECTORS, A	2003	3,782	378	10	378		945	18
19	PROJ 01.06 ACUTE CARE RENOVATION WASTE DISPOSAL	2003	754	50	15	50		126	19
20	PROJ 02.13 PHARMACY SECURITY WINDOW COUNTER SHUTTE	2003	1,432	95	15	95		239	20
21	PROJ 02.13 PHARMACY SECURITY LOCKS, MATERIALS	2003	538	108	5	108		269	21
22	PROJ 02.13 PHARMACY SECURIT WINDOW PROF SERV RICKA	2003	1,102	73	15	73		184	22
23	PROJ 02.16 RADIOLOGY RENOVATION SHELVING	2003	1,697	113	15	113		283	23
24	PROJ 01.06 ACUTE CARE RENO WIRING/CABLE FOR NETWOR	2003	3,625	725	5	725		1,812	24
25	PROJ 01.06 ACUTE CARE RENO WALK IN COOLER	2003	2,393	160	15	160		399	25
26	PROJ 01.06 ACUTE CARE RENO FIBERGLASS SOUND CONTRO	2003	695	58	12	58		145	26
27	PROJ 01.06 ACUTE CARE RENO LAMINATE CASEWORK/COUNT	2003	8,495	566	15	566		1,416	27
28	PROJ 01.06 ACUTE CARE RENO SPRINKLER SYSTEM W/TIME	2003	859	34	25	34		86	28
29	04.08 MAIN STREET PROJECT- RELOCATE FIBER OPTIC	2005	2,803	93	15	93		93	29
30	04.09 PHASE II UTILITY YARD- HEATERS FOR NITROUS T	2005	1,089	54	10	54		54	30
31	04.09 PHASE II UTILITY YARD- TEST SPRINKLER SYSTEM	2005	990	49	10	49		49	31
32	04.09 PHASE II UTILITY YARD- GENERATOR REPAIRS & P	2005	1,710	86	10	86		86	32
33	04.09 PHASE II UTILITY YARD- ELECTRICAL SUPPLIES &	2005	1,226	61	10	61		61	33
34	TOTAL (lines 1 thru 33)		$ 13,097,039	$ 376,388		$ 376,388	$	$ 8,840,627	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 13,097,039	$ 376,388		$ 376,388	$	$ 8,840,627	1
2	04.09 PHASE II UTILITY YARD- CHILLER & WATER LINES	2005	2,465	82	VARIOUS	82		82	2
3	04.09 PHASE II UTILITY YARD- ASBESTOS REMOVAL	2005	575	19	VARIOUS	19		19	3
4	Land Improvements	1971	32,917		VARIOUS			32,917	4
5	Land Improvements	1976	82,444		VARIOUS			82,444	5
6	Land Improvements	1979	30,209		VARIOUS			30,208	6
7	Land Improvements	1981	65,066		VARIOUS			65,066	7
8	Land Improvements	1984	61,686	1,612	VARIOUS	1,612		56,078	8
9	Land Improvements	1991	13,023	21	VARIOUS	21		12,979	9
10	Land Improvements	1992	656		VARIOUS			654	10
11	Land Improvements	1993	3,134	100	VARIOUS	100		3,021	11
12	Land Improvements	1994	3,983	244	VARIOUS	244		3,117	12
13	Land Improvements	1995	1,178		VARIOUS			1,175	13
14	Land Improvements	1996	3,963		VARIOUS			3,953	14
15	Land Improvements	1998	442	29	VARIOUS	29		220	15
16	Land Improvements	2001	6,453	645	VARIOUS	645		2,904	16
17	PROJ. 02.06 BLACKTOP ALLEY--BLACKTOP ALLEY BY S. P	2002	3,288	411	8	411		1,439	17
18	DEMOLITION OF ONE HOUSE MAPLE ST, ONE HOUSE AVE B	2002	6,515	326	20	326		1,140	18
19	01.07 MRI PROJ--LANDSCAPING	2002	1,165	233	5	233		816	19
20	01.07 MRI PROJ--LANDSCAPING/FLAG POLE	2002	758	38	20	38		133	20
21	RESURFACE, SEAL & STRIPE SOUTH PARKING LOT	2003	3,569	446	8	446		1,115	21
22	CONCRETE BETWEEN E. ENTRANCE AND LOADING DOCK	2003	467	31	15	31		78	22
23	HOUSE DEMOLITION 253 W. WALNUT	2003	2,395	240	10	240		599	23
24	HOUSE DEMOLITION 23 W. WALNUT	2003	3,310	331	10	331		827	24
25	HOUSE DEMOLTION 251 W. WALNUT	2003	5,770	577	10	577		1,443	25
26	01.07 MRI PROJECT LANDSCAPING	2003	479	96	5	96		240	26
27	PROJ 02.11 PAVE WEST PARKING LOT	2003	20,988	2,623	8	2,623		6,559	27
28	PROJ 04.02 AMERICAN LEGION PROPERTY-EXCAVATE, FILL	2004	83,693	5,580	15	5,580		8,369	28
29	SEE ATTACHED FOR 2005 LAND IMPROVEMENTS	2005	84,686	2,844	VARIOUS	2,844		2,844	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,622,316	$ 392,916		$ 392,916	$	$ 9,161,066	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 191,896	$ 16,971	$ 16,971	$		$ 65,730	71
72	Current Year Purchases	10,935	924	924				72
73	Fully Depreciated Assets	107,454					107,189	73
74								74
75	TOTALS	$ 310,285	$ 17,895	$ 17,895	$		$ 172,919	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,932,601	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 410,811	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 410,811	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,333,985	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Graham Hospital # 8000200 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,724,127	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,381,475		3
4	Supply Inventory (priced at)	1,057,926		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	558,602		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,722,130	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	26,348,300		12
13	Land	2,921,367		13
14	Buildings, at Historical Cost	22,641,337		14
15	Leasehold Improvements, at Historical Cost	18,252,446		15
16	Equipment, at Historical Cost	18,813,224		16
17	Accumulated Depreciation (book methods)	(37,718,598)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	48,851		21
22	Other Long-Term Assets (specify):	1,104,730		22
23	Other(specify):	8,981,718		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 61,393,375	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 70,115,505	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,135,054	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	3,880,477		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,015,531	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Est. Self Insurance Costs	1,194,577		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,194,577	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,210,108	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 63,905,397	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 70,115,505	$	48

***(See instructions.)**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 62,084,209	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 62,084,209	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,392,461	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	118,572	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Change in unreal loss on investments and chai	8,153	15
16	Other (describe) Increase in interest in perpetual trusts	38,358	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 4,557,544	17
	B. Transfers (Itemize):		
18	Transfer to Affiliate	(2,736,356)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2,736,356)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 63,905,397	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 79,629,871	1
2	Discounts and Allowances for all Levels	(39,480,494)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 40,149,377	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	308,681	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	234,301	16
17	Sale of Drugs	334,827	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	630,323	19
20	Radiology and X-Ray		20
21	Other Medical Services	877,990	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,386,122	23
	D. Non-Operating Revenue		
24	Contributions	60,488	24
25	Interest and Other Investment Income***	1,749,071	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,809,559	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	School of Nursing	402,170	28
28a	Kelley Home	49,512	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 451,682	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 44,796,740	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services		31
32	Health Care	30,547,149	32
33	General Administration	9,831,962	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Loss on disposal of equipment	25,168	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 40,404,279	40
41	**Income before Income Taxes (line 30 minus line 40)****	4,392,461	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 4,392,461	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)			$ *	$	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$

TOTAL (agree to Schedule V, line 17, col. 1)
(List each licensed administrator separately.) $

B. Administrative - Other

Description	Amount
	$

TOTAL (agree to Schedule V, line 17, col. 3) $
(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
		$

TOTAL (agree to Schedule V, line 19, column 3)
(If total legal fees exceed $2500 attach copy of invoices.) $

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	

TOTAL (agree to Schedule V, line 22, col.8) $

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$

TOTAL $

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )

TOTAL (agree to Sch. V, line 20, col. 8) $

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )

TOTAL (agree to Sch. V, line 24, col. 8) $

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Graham Hospital **#** 8000200 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5-10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **NONE** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **29,565**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **BKD, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.